Department of Health and Human Services
Assertive Community Treatment (ACT) Self-Fidelity Response

CMHC:	**Greater Nashua Mental Health Center (GNMHC)**
DHHS Response Date:	**12/9/16 2nd response 1/24/17**

Executive Summary:

Thank you for this ACT Fidelity Report, the thorough self-evaluations, and your on-going efforts to provide high quality services to consumers with psychiatric disabilities.

The report indicates that the ACT service provided by GNCMHC were rated 115/140, "Good Fidelity." However, some areas of the review require additional information to substantiate the rating. Please consider our comments and questions on these items, and then update your ratings if needed, and modify your report for the following items:

H3 – Does team review all clients at each meeting?

H4 - What proportion of time does the team leader have for administration and supervision of the team?
H7 &H8 – please show the formula calculations demonstrating at how you arrived at your rating;
O1 – Does the CMHC have explicit admission criteria?
O4 - The team has a crisis line, but are they responsible for covering psychiatric crises 24/7?
O6 – What proportion of people with hospital discharges had team involvement in discharge planning?
S1 – Based on chart audit, what proportion of visits were community based?
S3 – Was there evidence of use of street outreach and legal mechanisms?
S4 – Please note that Phoenix data of consumers served within ACT cost center indicated that ACT consumers receive an average of 87 minutes of service/week, a dramatically lower number than the number obtained via the record review. The report did not indicate how many records were reviewed and whether they were randomly selected.
S5 - Please note that Phoenix data of consumers served within the ACT cost center over the past quarter indicated that ACT consumers receive an average of 3.1 service/week, a number that is lower than the number obtained via the record review. The report did not indicate how many records were reviewed and whether they were randomly selected.

We agree with the plans in your Areas of Focus section of the Fidelity report.

Below are the items rated 3 or less that we recommend for priority focus. We encourage you to consider addressing the areas not yet addressed with a long-range plan for improvement. Please update your "Areas of focus" section to include specific actions steps and target completion timelines for all items in the Areas of focus section.

- H6 Staff Capacity: 3 out of 5
- H7 Psychiatrist on team: 3 out of 5
- H8 Nurse on team: 3 out of 5
- S6 Work with information support system: 2 out of 5
- S7 Individualized substance abuse treatment: 3 out of 5
- S8 Co-Occurring disorder treatment groups: 1 out of 5
- S10 Role of consumers on team: 1 out of 5

We commend you for your plans to enhance the capacity for integrated stage-wise, co-occurring substance abuse treatment. We also commend you for particularly high fidelity in the following areas:

- H3 Program meeting
- H9 Substance abuse specialist on team
- H10 Vocational specialist on team

Please keep in mind that the Office of Consumer and Family Affairs offers a monthly peer specialist support group that would be helpful for ACT Peer Specialist(s). We encourage the ACT team to link consumer ACT staff to this group once those individuals are hired.

Please update your review and report as requested above and resubmit to Michele Harlan by January 6, 2016.

DHHS appreciates the thorough review and updated responses received on January 9, 2017. The Area of focus on the original Fidelity report was not updated, instead a separate document addressing items with lower ratings was sent. Upon review we have determined that Nashua is reasonably in compliance with the purpose and intent of the ACT self-fidelity process. We have updated the DHHS response herein accordingly.

Several Fidelity items need additional review to ensure that they were assessed and rated as intended by the toolkit.

H-2: Is there a team approach in which clinicians know and work with all clients?

O-6: A specific percentage is needed to earn a rating of 5

S-1: The specific proportion of services that are community based services is needed to demonstrate the rating of 5

There was one item in which the score was lowered:

H-3 Team Meeting was lowered from a 5 to a 4, as each consumer is not reviewed at each meeting.

We agree with your plans for improvement. The Areas of Focus section and review response will be the basis for any technical assistance and follow-up activities with BMHS.

Out of a possible 140 points the CMHC reported a score of:	Updated score of 114

Improvement Plan Required: Yes			No further action needed		Resubmit: Address items: As above

Score Range	Implementation Rating
113 – 140	Good Implementation
85 – 112	Fair Implementation
84 and below	Not Assertive Community Treatment

Human Resources: Structure and Composition

H1 Small caseload: Consumer/provider ratio = 10:1	**Rating = 5 out of 5**
DHHS Response:	**Acceptable recommendation**

H2 Team approach: Provider group functions as team rather than as individual ACT team members; ACT team members know and work with all consumers	**Rating = 4 out of 5**
DHHS Response:	**Acceptable recommendation** The response to H4 suggests that this rating may not be accurate. In this model, clinicians know and work with all clients – this ensures continuity of care for clients, and creates a supportive organizational environment for practitioners. Please review the rating for this item and work with the team to ensure a team approach.

H3 Program meeting: Meets often to plan and review services for each consumer	**Rating = 5 out of 5** **DHHS rating = 4 out of 5**
DHHS Response:	**Please clarify - Does team review all clients at each meeting?** **Agency response:** Our ACT teams meet 5 times per week and although they do not review all of the clients at each meeting the clients are all reviewed as an entire team on at least a weekly basis. The ACT caseloads are reviewed at all meetings by team leads and primary clinicians even though they may not be discussed with the entire team at every meeting. A rating of 4 requires only meeting 2 to 4 times per week which our ACT teams exceed so a rating of 4 does not capture the commitment of the team to reviewing the clients on a frequent and

	consistent basis**.** DHHS response: We recognize the commitment of the team, but a rating of 5 is made when all consumers are reviewed at each meeting; if only briefly.

H4 Practicing ACT leader: Supervisor of Frontline ACT team members provides direct services		**Rating = 5 out of 5**
DHHS Response:	**Please clarify - What proportion of time does the team leader have for administration and supervision of the team?** **Agency response:** Our ACT Team Leaders each carry a caseload ranging from 6 to 9 clients. They routinely provide direct clinical care both individually and in the context of assisting their team members with clients. At least 50% of an ACT team leads time is spent providing direct care. Total time they are providing direct care at least 50%. DHHS Response: Agree, but this response refers to "caseload." ACT is a model in which there is not an assigned caseload. As measured in item H2, "Team Approach," this response suggests that the rating of H2 may not be accurate. In this model, clinicians know and work with all clients – this ensures continuity of care for clients, and creates a supportive organizational environment for practitioners.	

H5 Continuity of staffing: Keeps same staffing over time		**Rating = 4 out of 5**
DHHS Response:	**Acceptable recommendation**	

H6 Staff capacity: Operates at full staffing		**Rating = 3 out of 5**
DHHS Response:	**Continue with efforts to recruit, hire and train the staff necessary for full staffing of the teams** **Agency response:** The ACT team functioned with low staffing for much of the previous year as the agency turnover rate has been	

	high and the available work force in New Hampshire is very limited. The impact of limited workforce is especially noticeable when looking to hire clinicians who have the experience needed to work with clients whose acuity level requires ACT services. As of October 2016, we have added three new master's level clinical staff. Currently there is only one vacant case manager position and a vacant peer support specialist position. We will be hiring an additional nurse and supported employment specialist once the once both ACT teams are carrying caseloads that can support these additional positions. DHHS Response: Acceptable recommendation.

H7 Psychiatrist on team: At least 1 full-time psychiatrist for 100 consumers works with program	**Rating = 3 out of 5**
DHHS Response:	**Please clarify by showing the formula calculations demonstrating at how you arrived at your rating; Continue with efforts to recruit a full-time psychiatrist.** **Agency response:** The ACT psychiatrist is our Chief Medical Officer and 60% of her time is allotted for administrative duties and 40% of her time is slated for the ACT Teams. For the most part, this is the time she is spending with ACT. Currently we have a nurse practitioner on medical leave so the psychiatrist is helping to cover her case load as well. As a result, currently her time maybe slightly less than 40%, but this is a temporary situation. The expectation of having a full time psychiatrist to work with only 100 clients is financially not feasible and therefore an unrealistic expectation. This is especially true considering the limited psychiatric resources in New Hampshire and the country as a whole. The agency is actively recruiting medical staff and, as resources increase, the ACT psychiatrist will no longer be covering another provider's caseload and will be able to resume her 40% clinical time with solely the ACT teams. An expectation of anything greater then this is not feasible under the current reimbursement structure and psychiatric availability. DHHS Response: Acceptable recommendation.

H8 Nurse on team: At least 2 full-time nurses assigned for a 100-consumer program	**Rating = 3 out of 5**
DHHS Response:	**Please clarify by showing the formula calculations demonstrating at how you arrived at your rating; Proceed with**

	discussions and plans to hire a second ACT nurse. **Agency response:** We have one full time nurse assigned to the ACT teams and 100% of her time is allotted to the 80 plus clients on the teams. A score of 3 is .8 to 1.39 FTEs for 100 consumers so we are well within that range. GNMHC is in the process of building the caseloads for both ACT teams. Once the number of clients served is able to sustain two full time nurses we will hire a second nurse. With each ACT team looking to add at least 3 clients per month the teams would be at capacity in approximately 9 months. (Expected # ACT clients 143 – Current # ACT clients 89 = 54 openings 54 openings/6 clients added per month = 9 months). DHHS Response: Acceptable recommendation.

H9 Substance abuse specialist on team: A 100-consumer program with at least 2 staff members with 1 year of training or clinical experience in substance abuse treatment	**Rating = 5 out of 5**
DHHS Response:	**Acceptable recommendation**

H10 Vocational specialist on team: At least 2 team members with 1 year training/experience in vocational rehabilitation and support	**Rating = 5 out of 5**
DHHS Response:	**Acceptable recommendation**

H11 Program size: Of sufficient absolute size to consistently provide necessary staffing diversity and coverage	**Rating = 5 out of 5**
DHHS Response:	**Acceptable recommendation**

Organizational Boundaries

O1 Explicit admission criteria: Has clearly identified mission to serve a particular population. Has and uses measurable and operationally defined criteria to screen out inappropriate referrals.	**Rating = 4 out of 5**
DHHS Response:	Please clarify - Does the CMHC have explicit admission criteria? **Acceptable recommendation** **Agency response:** Yes, we have both specific admission criteria and

	a referral form that prompts referring clinicians to review each of these criteria when referring. It is not required that a client meet all the criteria, but we expect that they meet a sufficient number to require ACT level of care. See attached. DHHS Response: Agree

O2 Intake rate: Takes consumers in at a low rate to maintain a stable service environment.	**Rating = 5 out of 5**
DHHS Response:	**Acceptable recommendation**

O3 Full responsibility for treatment services: In addition to case management, directly provides psychiatric services, counseling/ psychotherapy, housing support, substance abuse treatment, employment and rehabilitative services.	**Rating = 4 out of 5**
DHHS Response:	**Acceptable recommendation**

O4 Responsibility for crisis services: Has 24-hour responsibility for covering psychiatric crises.	**Rating = 5 out of 5**
DHHS Response:	**Please clarify - The team has a crisis line, but are they responsible for covering psychiatric crises 24/7?** **Agency response:** Yes, our ACT teams have a dedicated ACT crisis line that is staffed by ACT clinicians 24/7. Provided it is safe for our clinicians, ACT staff will respond to crisis in the community or hospitals if needed. Our ACT team has recently changed their regular working hours from 8 am - 4pm to 8 am – 6:30pm to allow for an increase in provision of services in the evenings and on weekends. DHHS Response: Agree

O5 Responsibility for hospital admissions: Is involved in hospital admissions.	**Rating = 5 out of 5**
DHHS Response:	**Acceptable recommendation**

O6 Responsibility for hospital discharge planning: Is involved in planning for hospital discharges.	**Rating = 5 out of 5**
DHHS Response:	**Please clarify - What proportion of people with hospital discharges had team involvement in discharge planning?** **Agency response:** Our ACT team is involved in all hospital discharges for those clients they are made aware of a hospital

	admission or discharge. Because our agency does not provide emergency services in the emergency departments at our local hospitals, there are situations in which clients have been discharged from the EDs without the team being notified. For example, this occurred when a client was waiting in the ED for a psychiatric hospital admission and the ED determined that they stabilized and discharged them without notifying the team. Although this has occurred only a handful of times, we are addressing the issue with the psychiatric emergency services teams in the EDs. On most occasions, the ED will consult with the ACT teams to help determine if a client is at baseline. Our ACT staff does always meet with clients while they are waiting in the EDs for hospitalization as they are not considered credentialed staff. DHHS Response: A rating of 5 is made when 91% or more of discharges involve the ACT Team, as obtained by reviewing records of ACT clients who were discharged in the past year. We recognize that there may be reasons why the ACT team was not involved, but the rating is made regardless of the reason. The method for the rating and data behind the rating are still not clear in the report; this rating can't be confirmed at this point.

O7 Time-unlimited services (graduation rate): Rarely closes cases but remains the point of contact for all consumers as needed.	**Rating = 5 out of 5**
DHHS Response:	**Acceptable recommendation**

Nature of Services

S1 Community-based services: Works to monitor status, develop community living skills in community rather than in office.	**Rating = 5 out of 5**
DHHS Response:	**Please clarify – Based on chart audit, what proportion of visits were community based?** DHHS Response: A rating of 5 is made when 10 chart reviews indicate that ≥80% of face-to-face contacts took place in the community rather than in the office. Clinician and client interviews should support the chart review findings, which are the primary source for this rating. The report still does not indicate how the rating of 5 was made; this rating can not be confirmed at this point.

S2 No dropout policy: Retains high percentage of consumers.	**Rating = 5 out of 5**
DHHS Response:	**Acceptable recommendation**

S3 Assertive engagement mechanisms: As part of ensuring engagement, uses street outreach and legal mechanisms (probation/parole, OP commitment) as indicated and as available.	**Rating = 4 out of 5**
DHHS Response:	**Please clarify – Was there evidence of use of street outreach and legal mechanisms?** **Agency response:** Yes, our staff documents all outreach attempts within our EMR system. Because our phone and note to file notes represent non-billable services, we do not always make these available to outside agencies. In the client records audited for the purpose of the ACT Fidelity audit, there was evidence of outreach attempts as well as legal mechanisms. DHHS Response: Agree.

S4 Intensity of service: High total amount of service time, as needed.	**Rating = 5 out of 5**
DHHS Response:	**Please note that Phoenix data of consumers served within ACT cost center indicated that ACT consumers receive an average of 87 minutes of service/week, a dramatically lower number than the number obtained via the record review. The report did not indicate how many records were reviewed and whether they were randomly selected. Please clarify.** **Agency response:** At the start of the ACT Fidelity audit, 20 names from each ACT team were presented to the auditor. From those 40 names, 10 clients from each team were randomly selected for the purpose of the audit. Within the audit, a 2 week time frame was selected to view all selected clients. Within those 2 weeks, our agency provided an average of 133 minutes of services/week to our clients. Because of our awareness of the low number based on Phoenix data, GNMHC has been striving to provide more services to clients to meet their needs which is reflected in the 2 week sample. DHHS Response: Agree

S5 Frequency of contact: High number of service contacts, as needed.	**Rating = 5 out of 5**
DHHS Response:	**Please note that Phoenix data of consumers served within the ACT cost center over the past quarter indicated that ACT consumers receive an average of 3.1 service/week, a number that is lower than the number obtained via the record review. The report did not indicate how many records were reviewed and whether they were randomly selected. Please clarify.** **Agency response:** At the start of the ACT Fidelity audit, 20 names from each ACT team were presented to the auditor. From those 40 names, 10 clients from each team were randomly selected for the purpose of the audit. Within the audit, a 2 week time frame was selected to view all selected clients. Within those 2 weeks, our agency provided an average of 5 services/week to our clients. Because of our awareness of the low number based on Phoenix data, GNMHC has been striving to provide more services to clients to meet their needs which is reflected in the 2 week sample. DHHS Response: Agree

S6 Work with informal support system: With or without consumer present, provides support and skills for consumer's support network: family, landlords, employers.	**Rating = 2 out of 5**
DHHS Response:	**Proceed with plan to increase contact with informal supports and to improve documentation around these activities. Provide an estimated timeframe for implementation.** **Agency response:** GNMHC will provide a review training to ACT staff on the importance and benefits of family and natural support interventions, including by partnering with NAMI and the local peer support agency. It is suspected that these contacts are occurring much more than is documented so training will also include the importance of documentation and consideration of changes to forms to more effectively capture these interventions. These trainings will occur during the third quarter of fiscal year 2017. DHHS Response: Acceptable recommendation.

S7 Individualized substance abuse treatment: 1 or more team members provides direct treatment and substance abuse treatment for consumers with substance-use disorders.	**Rating = 3 out of 5**
DHHS Response:	**Proceed with discussions and planning to adopt specialized SA treatment staff within the ACT team(s); provide an estimated time for implementation.** **Agency response:** A proposal has been written to have Integrated Treatment for Co-Occurring Disorders training offered to all clinical staff at GNMHC. The expectation would be that all ACT staff attend the training. Following the training, this EBP would be incorporated into treatment and followed up on in supervision and with refresher trainings. The training will be scheduled as soon as the funding is approved. We are hoping to be able to offer it sometime in the third quarter of fiscal year 2017. DHHS Response: Acceptable recommendation

S8 Co-Occurring disorder treatment groups: Uses group modalities as treatment strategy for consumers with substance-use disorders.	**Rating = 1 out of 5**
DHHS Response:	**Proceed with plans to resume an ACT substance abuse group; provide a timeframe for implementation.** **Agency response:** Currently our ACT staff is developing an ACT specific substance abuse group. We plan to have the group begin after the Integrated Treatment for Co-Occurring Disorders training has occurred (see above). We are looking to start the group in the fourth quarter of fiscal year 2017. DHHS Response: Acceptable recommendation

S9 Dual Disorders (DD) Model: Uses a non-confrontational, stage-wise treatment model, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence.	**Rating = 4 out of 5**
DHHS Response:	**Acceptable recommendation**

S10 Role of consumers on team: Consumers involved as team members providing direct services.	**Rating = 1 out of 5**
DHHS Response:	**Proceed with plans to increase peer services and hire a full time Peer Specialist to work with the ACT team. Provide an estimated time frame for implementation.** **Agency response:** We have been in contact with our local peer support center to collaborate with them about hiring a Peer Specialist. They are open to this idea and we will be working out the details of the collaboration in the coming months. DHHS Response: Acceptable recommendation